STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: April 09, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026258

[redacted]

[redacted]

On February 23, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's denial of eligibility to enroll into health insurance through NYSOH.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of NY State of Health.

If you have questions about your Decision, you can contact us by:

- Calling the Customer Service Center at 1-855-355-5777
- Sending Mail to:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- Sending a Fax to 1-855-900-5557

When contacting NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification number and the NY State of Health number at the top of this notice.

Legal Authority

We are sending you this notice in accordance with 45 Code of Federal Regulations (CFR) § 155.545.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

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DEPARTMENT OF HEALTH
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Decision

Decision Date: April 09, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP0000000026258

[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did NY State of Health properly determine that you were ineligible for health insurance coverage through NYSOH?

Procedural History

On October 24, 2017, NY State of Health (NYSOH) issued a renewal notice stating that it was time for you to renew your health insurance coverage for the upcoming coverage year. This notice further stated that based on federal and state data sources, NYSOH could not make a decision about whether you qualified for financial help paying for your health insurance coverage. The notice directed you to update your NYSOH account between November 16, 2017 and December 15, 2017, so that NYSOH could make the appropriate decision.

On December 12, 2017, NYSOH received five applications for financial assistance through NYSOH. That day a preliminary determination was prepared stating that you were ineligible to purchase health insurance through NYSOH.

On December 13, 2017, NYSOH issued a plan disenrollment notice stating that you were no longer enrolled in your Essential Plan coverage as of January 31, 2018.

On December 22, 2017, you spoke to the NYSOH's Accounts Review unit and requested an appeal, insofar, you were found ineligible to enroll in health insurance coverage with financial assistance through NYSOH.

On February 23, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of the hearing.

Findings of Fact

A review of the record supports the following findings of fact:

1) According to your NYSOH account and testimony, you are applying for health insurance for yourself.

2) You testified that you want to be determined eligible for the Essential Plan.

3) You testfied that you are [redacted].

4) You testified that the only income you receive is from your Social Security Disability benefit.

5) You testfied that you started to receive Social Security Disability benefits around the Spring of 2016.

6) According to your NYSOH account, you do not have any dependents.

7) According to your NYSOH account, you have been enrolled in Medicare since June 1, 2017.

8) You testified that you are only enrolled in Medicare Part A.

9) You testfied that you were enrolled in Medicare Part B, but, as of the date of hearing, this coverage was canceled.

10) You testfied that you canceled your Medicare Part B benefits because you were receiving affordable health coverage through NYSOH at the time you became eligible to enroll into Part B coverage.

11) You testfied that you did not know what Medicare Part B coverage was prior to canceling it.

12) You testfied that you were not aware that having Medicare coverage would make you ineligible for health insurance through NYSOH at the time you canceled your Medicare Part B coverage.

13) You testified that you have applied for Medicaid through your local Department of Social Services, but your application was denied.

14) You testfied that, at the time of telephone hearing, you had an appeal pending with Medicare to see if you were eligible to reenroll into Medicare Part B coverage.

15) You testfied that you have [redacted] which requires constant medical treatment and having health insurance is an important part of maintaining this chronic condition.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

De Novo Review

NYSOH Appeals Unit must review each appeal de novo and "consider all relevant facts and evidence adduced during the appeals process" (45 CFR § 155.535(f)). "De novo review means a review of an appeal without deference to prior decisions in the case" (45 CFR § 155.500).

Qualified Health Plan

It is unlawful for a person to sell or issue to an individual, entitled to benefits under Medicare Part A or enrolled under Medicare Part B, a health insurance policy with the knowledge that the policy duplicates health benefits to which the individual is otherwise entitled to be enrolled in (42 U.S. Code § 1395ss(d)(3)(A); https://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Downloads/Medicare-Marketplace_Master_FAQ_4-28-16_v2.pdf (last updated April 28, 2016).

Essential Plan

NYSOH must generally determine an applicant eligible for the Essential Plan, a basic health plan, if the person is (1) a resident of New York State, (2) expects to have a household income between 138% and 200% of the applicable federal poverty level (FPL) or, in the case of an individual who is a lawfully present non-citizen who is ineligible for Medicaid or Child Health Plus as a result of their immigration status, has a household income that is between 0% and 200% of the FPL, (3) is not otherwise eligible for minimum essential coverage except through the individual market, (4) is 64 years old or younger, (5) is a citizen or a lawfully present non-citizen, and (6) is not incarcerated (*see* 42 CFR § 600.305, 42 CFR § 435.603(d)(4), 45 CFR § 155.305(e), NY Social Services Law § 369-gg(3), 42 USC § 18051).

Minimum essential coverage includes most government-sponsored insurance plans such as Medicaid, Medicare, CHIP, Tricare, Veterans' Health Coverage, and eligible employer-sponsored insurance (26 USC §§ 36B(c)(2)(B) and 5000A(f)).

Medicaid

An individual is eligible for enrollment in Medicaid through NYSOH (called MAGI-based Medicaid) when he or she meets certain nonfinancial criteria and has a household income that is at or below the applicable Medicaid income standard (45 CFR § 155.305(c); N.Y. Soc. Serv. Law § 366(1)(b)).

In general, to qualify for MAGI-based Medicaid through NYSOH, you must also be one of the following:

- An adult aged 19-64 who is not eligible for Medicare Part A or Part B,
- A pregnant woman or infant,
- A child aged 1-18, or
- A parent or caretaker relative

(45 CFR § 155.305(c); N.Y. Soc. Serv. Law § 366(1)(b)).

If an individual does not fall into one of these categories, he or she may still be eligible for non-MAGI-based Medicaid coverage through their Local Department of Social Services or the New York City Human Resources Administration (*see* N.Y. Soc. Serv. Law § 366(1)(c)).

Legal Analysis

The issue under review is whether you were properly determined ineligible for health insurance through NYSOH.

You testified that you are appealing the denial of eligibility for health insurance through NYSOH. However, the record does not contain a notice of eligibility determination on the issue of whether you are eligible for health insurance through NYSOH.

Here, the lack of a notice of eligibility determination does not prevent the Appeals Unit from reaching the merits of the case or constitute material error. Under 45 CFR § 155.505(b), you are as entitled to appeal NYSOH failure to timely issue a notice of eligibility determination as you are to appeal an adverse notice of eligibility determination.

Your credible testimony along with the December 23, 2017 appeal confirmation notice stating that the reason for your appeal was “Eligibility Determination”,

permits an inference that NYSOH did find you ineligible to enroll into health insurance coverage through NYSOH.

Since the Appeals Unit review of NYSOH determinations is performed on a de novo basis, no deference would have been granted to the eligibility determination notice had it been issued.

The sale or issuance of duplicate health insurance coverage to Medicare beneficiaries, including qualified health plans through NYSOH, is prohibited. The record reflects that you have been enrolled in Medicare Parts A since June 1, 2017. Therefore, you were not eligible to enroll in a qualified health plan at full cost through NYSOH.

The Essential Plan is available to individuals who are not otherwise eligible for minimum essential coverage. Various government-sponsored plans provide minimum essential coverage, including Part A of the Medicare program. Again, since you have been enrolled in Medicare Parts A since June 1, 2017, you were not eligible to enroll in the Essential Plan because you were enrolled in minimum essential coverage.

Medicaid through NYSOH is available to individuals who are between the ages of 19 and 64, who are not eligible for Medicare Parts A or B; pregnant women or infants; children between the ages of 1 and 18; and parent or caretaker relatives.

The record reflects that, when NYSOH issued the preliminary eligibility determination on December 12, 2017, you were eligible for both Medicare Part A and Part B, but you were only enrolled in Medicare Part A. Furthermore, the record reflects that you have no dependents and, therefore, are not a parent or a caretaker relative of a dependent child. Therefore, you do not qualify for Medicaid on that basis. Since you were enrolled in Medicare and were not a parent or caretaker relative, NYSOH properly determined that you were not eligible for Medicaid through NYSOH.

Therefore, you were properly determined ineligible to enroll in health insurance through NYSOH, and the preliminary eligibility determination to this effect is AFFIRMED.

Decision

NYSOH’s preliminary eligibility determination stating that you were ineligible to enroll into health insurance coverage through NYSOH is AFFIRMED.

Effective Date of this Decision: April 09, 2018

How this Decision Affects Your Eligibility

You are ineligible to enroll into health insurance through NYSOH.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to the Federal Marketplace or bring a lawsuit under New York Civil Practice Law and Rules, Article 78.

You may bring a lawsuit on any Appeals Unit decision in New York State court in accordance with Article 78 of the New York Civil Practice Law and Rules. This must be done within four months of the Decision Date, which appears on the first page of this Decision.

Additionally, Appeals Unit decisions on issues involving eligibility for qualified health plans, advance premium tax credits, and cost-sharing reductions may be appealed to the Federal Marketplace. This must be done within 30 days of the Decision Date, which appears on the first page of this Decision (45 CFR § 155.520(c)).

If you have questions about appealing to the Federal Marketplace, you can contact them in any of the following ways:

- By calling the Customer Service Center at 1-800-318-2596
- By mail at:

  Health Insurance Marketplace
  Attn: Appeals
  465 Industrial Blvd.
  London, KY 40750-0061

- By fax: 1-877-369-0129

If you wish to be represented by an attorney in bringing an outside appeal and do not know how to go about getting one, you may contact legal resources available to you. You may, for example, contact the local County Bar Association, Legal Aid, or Legal Services.

If You Have Questions about this Decision (Customer Service Resources):

You can contact us in any of the following ways:

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

- By calling the Customer Service Center at 1-855-355-5777
- By mail at:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

NYSOH's preliminary eligibility determination stating that you were ineligible to enroll into health insurance coverage through NYSOH is AFFIRMED.

You are ineligible to enroll into health insurance through NYSOH.

Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.545(a).

A Copy of this Decision Has Been Provided To:

[redacted]

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

Getting Help in a Language Other than English

This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.

Español (Spanish)

Este es un documento importante. Si necesita ayuda para entenderlo, llame al 1-855-355-5777. Le proporcionaremos un intérprete sin ningún costo.

中文 (Traditional Chinese)

這是重要的文件。 如果您需要獲得關於瞭解文件內容方面的協助，請致電 1-855-355-5777。我們可以為您免費提供您所使用語言的翻譯人員。

Kreyòl Ayisyen (Haitian Creole)

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo 1-855-355-5777. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

中文 (Simplified Chinese)

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您免费提供相应语种的口译服务。

Italiano (Italian)

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Possiamo metterle a disposizione un interprete nella sua lingua.

한국어 (Korean)

중요한 서류입니다. 이해하는 데 도움이 필요하시면 1-855-355-5777 번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

Русский (Russian)

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-355-5777. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

العربية (Arabic)

هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم 1-855-355-5777. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجانًا.

বাংলা (Bengali)

এটি এক গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয় তাহলে, অনুগ্রহ করে 1-855-355-5777 নম্বরে কল করুন। আপনি যে ভাষায় কথা বলেন বিনামূল্যে আমরা আপনাকে একজন দোভাষী দিতে পারি।

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

Français (French)

Ceci est un document important. Si vous avez besoin d'aide pour en comprendre le contenu, appelez le 1-855-355-5777. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

हिंदी (Hindi)

यह एक महत्वपूर्ण दस्तावेज़ है। अगर आपको इसे समझने में सहायता चाहिए, तो कृपया 1-855-355-5777 पर कॉल करें। हम आपकी भाषा बोलने वाला एक दुभाषिया निःशुल्क उपलब्ध करवा सकते हैं।

日本語 (Japanese)

これは重要な書類です。理解するために支援が必要な場合は、1-855-355-5777 にお電話ください。通訳を無料で提供いたします。

नेपाली (Nepali)

यो एउटा महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई नि:शुल्क दोभाषे उपलब्ध गराउन सक्छौं।

Polski (Polish)

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer 1-855-355-5777. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

Twi (Twi)

Krataa yi yɛ tow krataa a ho hia. Sɛ wo hia ɛho nkyerɛkyerɛmu a, yɛ srɛ wo, frɛ 1-855-355-5777. yƐbƐtumi ama wo obi a ɔkyerƐ kasa a woka no ase ama wo kwa a wontua hwee.

اردو (Urdu)

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

Tiếng Việt (Vietnamese)

Đây là tài liệu quan trọng. Nếu quý vị cần trợ giúp để hiểu tài liệu này, vui lòng gọi 1-855-355-5777. Chúng tôi có thể cung cấp thông dịch viên miễn phí nói ngôn ngữ của quý vị.

אידיש (Yiddish)

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען אייך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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